4.15.1

Redetermination Requirements

A. General

All Medi-Cal beneficiaries must have their eligibility for Medi-Cal redetermined every 12 months. It is the worker's responsibility to complete the redetermination within 12 months of the approval of eligibility on any application, reapplication, or restoration, which required a Statement of Facts or within 12 months of the last redetermination. This section details the redetermination requirements.

B. Redetermination Due Dates

The table below shows when the redeterminations are due.

Example 1: Application approved in application month											
1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application & approval month					MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month
1/05	**2/05**	**3/05**	**4/05**	**5/04**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year					MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month
Example 2: Application with Retroactive Months											
										11/03	**12/03**
										Retro Eligible	Retro Eligible
1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Eligible	Approval Month Eligible				MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month
1/05	**2/05**	**3/05**	**4/05**	**5/05**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year					MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month
Example 3: Eligibility Criteria Not Met in Month of Application											
1/05	**2/05**	**3/05**	**4/05**	**5/05**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
	One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven
Application Month	Approval Month Eligible					MSR mail month	MSR due month			Annual RV mail month	Annual RV return month
1/06	**2/06**	**3/06**	**4/06**	**5/06**	**6/06**	**7/06**	**8/06**	**9/06**	**10/06**	**11/06**	**12/06**
Twelve	One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven

Annual RV due month	Benefits re-determined for 2nd year					MSR mail month	MSR due month			Annual RV mail month	Annual RV return month
Example 4: Family Members Have Different Initial Eligibility Dates											
1/05	**2/05**	**3/05**	**4/05**	**5/05**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Children Eligible Parents Over Property	Parents Eligible Due to Spend-Down				MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month
1/06	**2/06**	**3/06**	**4/06**	**5/06**	**6/06**	**7/06**	**8/06**	**9/06**	**10/06**	**11/06**	**12/06**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year					MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month
Example 5: MFBU with 3 children eligible for CEC Program and two different CEC periods											
1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Parents and child 1 & 2 MFBU eligible with no SOC	Approval month			Child 3 returns home with own CEC period	MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month CEC ends for children 1 & 2
1/05	**2/05**	**3/05**	**4/05**	**5/05**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
CEC continues for child 3	CEC continues for child 3	CEC ends for child 3			MSR mail month	MSR due month			Annual RV mail month	Annual RV return month	Annual RV due month

C. Statement of Facts

As part of the redetermination process, the beneficiary, or person acting on behalf of the beneficiary, is required to complete a new Statement of Facts.

D. Mail-In Redetermination

All redeterminations are completed by mail, except for the following:

- Beneficiaries who request a face-to-face interview, or
- When the worker determines good cause exists to require a face-to-face interview, including but not limited to:
  - questionable information on the redetermination form or verifications provided;
  - individual/family has no visible means of support such as in-kind income or means of support is not reported for the individual and/ or family;
  - obvious discrepancies between information reported on the redetermination form and IEVS on assets or income; or
  - a self-employed individual whose income and expenses do not match reported income and that questionable information could not be resolved with follow-up telephone contact and/or mail.

The worker will determine if a face-to-face interview is needed after the beneficiary submits the redetermination form. When a beneficiary must attend a face-to-face interview, the reason(s) must be documented in the case.

E. Verification Requests

When a beneficiary reports information on the Statement of Facts that requires verification, but fails to provide the verification when the Statement of Facts is returned timely, workers must follow the SB 87 process to obtain them. Workers must avoid unnecessary and repetitive requests of the beneficiary to provide the verification when the worker can obtain the verification through available sources such as other case records or is available through MEDS, IEVS, SAVE, etc. When a beneficiary reports information on the Statement of Facts that requires the worker to send additional form(s) for completion, the worker shall document the reason in the case record.

Only the items indicated in F below, are required to be verified at the redetermination. Do not request verifications other than those listed below unless it is determined that the additional verification is necessary to make an accurate eligibility determination. When such verification is requested, the verification type and the reason for the request must be narrated.

F. Information to be Verified

The following items must be verified at the redetermination:

- Incapacity,
- Legal responsibility for a child applying alone,
- Refusal of the parent to apply for an 18-21 year old child,
- Income; except income received from the United States Government, when the current benefit amount has previously been verified,
- Status and value of nonexempt property, and
- Immigration status; except for beneficiaries receiving restricted benefits.

G. Social Security Number (SSN)

It is not necessary to re-verify SSNs at redetermination. However, if during the redetermination process the worker discovers that the SSN of a beneficiary has not been previously verified, advise the beneficiary that he/she has 60 days to provide acceptable verification of the SSN or evidence of application for the SSN. Refer to MPG Article 4, Section 11 for SSN referral/verification.

H. Citizenship and Identity

ACWDL 07-12

When a beneficiary reports a change in their citizenship status at annual redetermination, the redetermination shall be certified as complete with no reduction in benefits if the only outstanding verifications are for citizenship and/or identity and the beneficiary is otherwise eligible and is making a good faith effort to provide the required citizenship and/or identity documents.

Refer to MPG 4-7-9 for instructions on requesting citizenship and/or identity documents.

4.15.2
Redetermination Forms

A. General

The forms listed in this section are used for the annual redetermination depending on the case circumstances.

B. Forms

The table below lists the forms and when they are used.

Form Number	Form Title	When Used
MC 210 RV	Medi-Cal Annual Redetermination	Used for all redeterminations not listed below.
MC 321 HFP	Application for Medi-Cal for Children and Healthy Families	Used for those families where the only beneficiaries are children receiving benefits under one of the FPL or property disregard programs.
MC 262	Redetermination for Medi-Cal Beneficiaries – Long-Term Care in Own MFBU	Used for beneficiaries receiving Medi-Cal under the long-term care aid codes.
MC 250 A	Application and Statement of Facts for an Individual Who is Over 18 and Under 21 and Who Was in Foster Care Placement on His or Her 18th Birthday	Used for beneficiaries receiving Medi-Cal in the Former Foster Care Children (FFCC) Program.
MC 210 PS	Property Supplement	Used if beneficiaries report a change in property or report fluctuating property (e.g. bank accounts) on the Statement of Facts and do not provide property verification.

C.
MC 210 RV

The MC 210 RV has been revised by the Department of Health Services (DHS). This revision replaces the MC 210 RV (8/99). The revised MC 210 RV eliminates the requirement to provide a Social Security Number (SSN) and date of birth for each household member. The top section of the MC 210 RV has the case identifying information. This information (Case number, Beneficiary's SSN, Beneficiary's date of birth, etc.) is labeled, "optional." The beneficiary does not have to provide this information. To avoid having returned MC 210 RVs being lost, the worker must enter the case number in the case number field when preparing the redetermination packet.

The MC 210 RV is also available on the DHS web site. It is possible that the FRC will receive MC 210 RV forms that were not sent by the worker, and so do not have the identifying information included. These forms will need to be cleared by address and each individual's name to identify the case and the proper worker. If a case cannot be located after clearing, the worker must attempt a phone call to the individual using the phone number listed on the form to request some identifying information so that the case can be located.

The MC 210 RV is divided into eight sections, with each section asking the beneficiary to provide information on specific subject matters with simple instructions and examples. The beneficiary is asked to attach supporting documentation of information reported on the MC 210 RV.

The following table highlights the purposes of each section:

Section	Title	Purpose
1	Income	Applies to income received by all MFBU members living in the home or temporarily away from home.
2	Expenses and Deductions	Applies to expenses MFBU members have to pay from income received. The beneficiary must provide supporting documentation before the allowable expense can be deducted from income.
3	Other Health Insurance	Applies to other health insurance that MFBU members may have.
4	Living Situation	Provides information on household changes that may affect linkage, program eligibility, and share of cost (SOC).

5	Real and Personal Property	Applies to all MFBU members who are receiving Medi-Cal. However, if the case contains only children or pregnant women receiving Medi-Cal under the federal poverty level (FPL) program and property information or documentation is not provided, these children and pregnant women, if eligible, must have their eligibility review completed without delay. For families that provide the real and personal property information, workers must first evaluate the family for 1931(b) eligibility before putting the children in the FPL programs.
6	Immigration or Citizenship Status Change	Applies to family members in the home who have a change in citizenship or immigration status. The beneficiary is not required to report the immigration or citizenship status of family members who are not in receipt of Medi-Cal.
7	Blindness/ Disability/ Incapacity	Allows the beneficiary to report any disabling condition not previously known or reported to the county.
8	Other Health Program Information and Referrals	Serves as a request for additional information on, or referral to, other programs and services available to low-income families.

D. Acting on the MC 210 RV

The table below shows the actions that the worker must take on the information reported in each section of the MC 210 RV.

If…	Then the worker must…
1) Income	
Income is reported, then the beneficiary is asked to provide documentation of all income received,	Review the source of income and treatment of that income for exemption and deductions.
In-kind income is reported,	• Contact the beneficiary to determine if the in-kind income is to be counted in the budget, • Allow applicable work-related deductions for earned in-kind income, and • Use the In-Kind Income and Housing Verification form (MC 210 S-I) if the beneficiary does not agree with the chart value of in-kind income.
2) Expenses and Deductions	

The beneficiary reports expenses, but supporting documentation is not provided with the MC 210 RV, and the expense was previously reported and the amount has not changed,	Review the existing case file for the documentation.
No supporting documentation is no file for the expense claimed,	• Contact the beneficiary and request documentation. • Continue to process the Annual Redetermination and not terminate benefits even if the beneficiary fails to provide the necessary documentation. • Certify the MFBU for another 12-month period and not allow the deduction(s) from income if all other eligibility factors are met.
Payment for health care is reported and it was not previously reported,	Review information in Section 3, Other Health Insurance, for follow-up.
Documentation is provided on health care insurance and premium payment,	Allow the deduction and continue to process the requirements for other health insurance.
3) Other Health Insurance	
The beneficiary reports other health coverage,	Compare the information with the case file.
The health coverage plan has not changed,	Not request the beneficiary to complete a new DHS 6155.
The health care coverage is new or has changed,	Send a new DHS 6155 to the beneficiary to complete and update the change in health care coverage on MEDS.
The beneficiary reports no change in health insurance being provided to a child who has an absent parent,	Not require the beneficiary to complete a new medical support questionnaire or other medical support information.
An individual is receiving Medi-Cal kidney dialysis-related services,	Request a copy of the SSA statement of Medicare status, or any evidence of eligibility if he/she has not provided such evidence previously.
The individual receiving Medi-Cal kidney-dialysis related services is not already receiving Medicare coverage,	Refer the individual to apply for Medicare coverage and provide evidence of application status.
4) Living Situation	
The beneficiary reports that someone has moved into or out of the home,	Review the case file to determine if the person is or is not an MFBU member.

If…	Then…
The person is an MFBU member,	The family's eligibility and/or benefit level may be affected by this change.

A new MFBU member is requesting Medi-Cal and being added to the case,	The beneficiary must provide information on the new person, such as income, property, health insurance, and immigration status before he/she can be added to the existing case. This requires a new application for the individual. The MC 210 RV cannot be used as an application for Medi-Cal benefits.

A newborn is reported and he/she is an MFBU member, and the parent has provided the newborn's place of birth (city and country),	Add the newborn to the existing case as the parent has completed the requirement of declaring the newborn's citizenship and satisfactory immigration status under penalty of perjury. The parent is not required to complete an MC 13 for the newborn. Also, no birth certificate is required to aid the infant.
An MFBU member is reported to be residing in a nursing facility or medical institution such as a board and care facility,	• Contact the beneficiary for more information. • Review income and property allocation as well as put the individual in his/her own MFBU.
A pregnant woman is reported living in the home,	Determine if that individual is an MFBU member.

If the pregnant woman is…	Then…
An MFBU member,	The worker must add the unborn to the MFBU and request that the pregnant woman provide pregnancy verification within 60 days.
An MFBU member not currently receiving Medi-Cal and requests pregnancy related services only,	She is allowed to self-declare her pregnancy has been medically verified if she is income eligible to the Income Disregard Program.
Not an MFBU member and requests Medi-Cal	The worker must contact the beneficiary and inform him/her that a Medi-Cal application will be mailed to the pregnant woman.

5) Real and Personal Property

The MFBU members are children or pregnant women receiving Medi-Cal under the federal poverty level (FPL) programs and property information or documentation is not provided,	Complete the eligibility review for these programs without delay.
The family provides property information and documentation,	Evaluate for 1931(b) before the FPL programs.

The MFBU contains adults and children from ages 19-21 who are also receiving Medi-Cal benefits,	Request property information for those individuals who are not eligible for the FPL programs. They must meet the property limits for Medi-Cal benefits to continue.
The family answers, "Yes" to questions 5(b) or 5(c) on the MC 210 RV,	Send out the MC 210 PS, Medi-Cal Property Supplement, for the beneficiary to complete.
The value of the reported property will affect eligibility,	• Contact the beneficiary and explain the spend-down provisions and require verification of the spend-down for eligibility to continue. • Document the disposition of any property sold or given away and the impact on the beneficiary's eligibility
Real or personal property was sold or transferred,	Ensure that the property was disposed of in a manner consistent with Medi-Cal policies and procedures.
Real or personal property has been previously reported and no information is reported to the worker on the disposition of the property,	Contact the beneficiary to clarify the change.
6) Immigration or Citizenship Status Change	
An immigration or citizenship status change is reported,	Review the case file to determine if the person with the status change is an MFBU member.
The reported change is for an MFBU member who is receiving Medi-Cal,	Mail an MC 13 for completion by that individual or representative.
The MFBU member claims a satisfactory immigration status (SIS) on the MC 13,	Grant full-scope Medi-Cal based on the redetermination date if the person was otherwise eligible at that time, and he/she was receiving restricted benefits prior to the redetermination.
The beneficiary completing the redetermination form is the person whose status has changed,	Not wait for receipt of the MC 13 to grant full scope Medi-Cal benefits, if otherwise eligible, but a new MC 13 must be provided for the case file. A beneficiary who claims a change from a restricted scope status to a full-scope status must provide evidence of their new status within 30 days of the claim or the time it takes to complete the redetermination process, whichever is longer.

An excluded MFBU member is not receiving Medi-Cal but now wants Medi-Cal	• Add the individual to the MFBU when the worker receives all appropriate information and verification on that individual. • Not delay the redetermination process for the MFBU pending the additional information or verification on the individual. The individual will remain excluded until all necessary documentation has been provided.
A non-MFBU member is reported to have a change to his/her immigration status and he/she is not receiving any type of Medi-Cal benefits,	Contact the beneficiary to determine if that person wants Medi-Cal.

If that individual is not…	Then the worker must…
An MFBU member and wants Medi-Cal,	Mail a Medi-Cal application to the household and inform them that he/she must complete the application and eligibility determination process.

7) Blindness/Disability/Incapacity	
The person claiming to have a disability is not currently receiving disability-linked Medi-Cal,	Contact the beneficiary to clarify the condition of the person reported as having the disability.
The person considers himself/herself to be blind or disabled,	• Send out the forms necessary to initiate a referral to the State Programs-Disability and Adult Programs Division (SP-DAPD) for evaluation. • Not make an independent determination that the condition is not severe enough to qualify the person as blind or disabled.
The beneficiary no longer has linkage to a Medi-Cal program, such as the last child has left home, and he/she claims to be disabled,	Continue the individual's Medi-Cal benefits during the disability evaluation process at the same benefit level that he/she was previously receiving.
A non-Medi-Cal parent in the home reports that he/she is incapacitated,	Contact the parent to determine if he/she wants Medi-Cal and document the results of that contact.
The beneficiary reports a person in the home has physical, mental, or health problems as a result of an injury or accident,	Contact the beneficiary and follow the procedures in Article 15, Section 3.
8) Other Health Program Information and Referrals	

The box is not checked indicating that the family does not want their child's information to be shared with Healthy Families (HF) and their child is determined to have a SOC,	• Share their information with the HF program. • Review the Medi-Cal to HF Bridging program for the SOC child.
The beneficiary requests CHDP services or additional CHDP information,	Complete a CHDP referral.
Information on a referral to Woman, Infants, and Children (WIC) is requested,	Contact the beneficiary to follow-up and document the referral process in the case file.
The beneficiary requests IHSS information,	Contact the beneficiary and provide the IHSS program telephone number.

E. Additional Forms

The table below shows the additional forms and the situations in which they must be provided. ACWDL 07-12

Form	Regular Medi-Cal or 1931(b)	Zero SOC Children Only	ABD	LTC
DHCS 0002	Change only	Change only	Change only	Change only
MC 003	X	X		
MC 219	X	X	X	X
MC 007	X	X	X	X
Postage Paid Envelope	X	X	X	X
16-69 HHSA	X	X	X	X
CHDP Brochure	X	X		
20-44 HHSA	X	X	X	X
Managed Care Information	X	X		
MC 13	Change only	Change only	Change only	Change only
14-59 HHSA	X			
CW 2.1	Change only	Change only		

F. Transitional Medi-Cal (TMC)

Beneficiaries receiving Medi-Cal under TMC are not required to complete an annual redetermination. The redetermination will be delayed for TMC beneficiaries until the end of their TMC period.

Non-TMC MFBU members are required to complete the annual redetermination when it is due. If non-TMC members fail to cooperate with the annual redetermination, only those members are to be terminated from Medi-Cal. The TMC eligible members will remain on TMC for the entire TMC period if they meet all TMC requirements. At the end of the TMC period, the worker must review the TMC beneficiary's eligibility under other Medi-Cal programs.
The table below provides examples of when the redetermination must be completed at the end of TMC.

If…	Then the worker must…
All MFBU members are receiving TMC and their annual redetermination is due before their TMC period expires,	Reset their redetermination month to the end of their TMC period. The redetermination for all MFBU members must be completed in the last month of their TMC period so that the worker may redetermine the MFBU's eligibility for other Medi-Cal programs.
MFBU members are receiving TMC with different TMC expiration dates,	Complete the redetermination for the first member(s) at the end of his/her TMC period. This redetermination will establish the next redetermination for the entire MFBU. At the end of the other MFBU member's TMC period, the worker must redetermine that individual's Medi-Cal benefits using information available in the existing case.
Some MFBU members are receiving TMC and others are not,	Complete the redetermination process for the other MFBU members. Once the redetermination is completed, the redetermination date is established for the entire MFBU.

G. CalWORKs

1) Parents receiving Medi-Cal only benefits in their children's CalWORKs case

Parents who are not cash eligible will receive Medi-Cal through the children's CalWORKs case. Since there is not a separate Medi-Cal only case, they will not be required to complete a separate Medi-Cal only redetermination as long as they cooperate with all the CalWORKs requirements for reporting changes and completing the annual renewal.

2) Resetting the annual redetermination date from a CalWORKs case

When the beneficiary is terminated from CalWORKs cash assistance for failure to complete the annual renewal, the case is placed into AC 38 pending a Medi-Cal evaluation. The next Medi-Cal annual redetermination will be 12 months from the Medi-Cal determination. See table below for an example.

									10/05	**11/05**	**12/05**
									CW RV overdue Disc	MC RV Pending	MC RV Completed
1/06	**2/06**	**3/06**	**4/06**	**5/06**	**6/06**	**7/06**	**8/06**	**9/06**	**10/06**	**11/06**	**12/06**
New 12-month Begins											MC RV Due

3) CalWORKs discontinued for non-cooperation with the annual renewal

Individuals on CalWORKs must not be terminated from Medi-Cal for failure to meet CalWORKs only requirements. When CalWORKs assistance is being terminated, the CalWORKs recipient's eligibility for Medi-Cal benefits must be reevaluated because the Medi-Cal program has less restrictive rules. For example, Medi-Cal only beneficiaries are not required to attend a face-to-face interview. If the parents in these CalWORKs cases fail to attend the face-to-face interview, the family can still get Medi-Cal if the parents cooperate with other requirements such as returning a completed Statement of Facts form. Therefore, when a CalWORKs case is discontinued for non-cooperation with the CalWORKs annual renewal, workers must ensure that the family is determined for ongoing Medi-Cal only benefits. The CalWORKs discontinuance should place the family in Aid Code (AC) 38 pending a determination for Medi-Cal only benefits. The table below shows when additional forms may be needed to complete the determination.

If the CalWORKs case file…	**Then the worker must…**

Contains current (within the last 30 days) information, such as a signed but incomplete SAWS 2,	• Continue to process the Medi-Cal redetermination using the information in the case file. • Follow SB 87 if additional information is needed.
Does not contain a current SAWS 2,	Send a Medi-Cal redetermination packet to the beneficiary with the instruction that his/her Medi-Cal benefits may also be terminated if the MC 210 RV is not returned to the county.

4.15.3
Complete and Incomplete Redetermination Forms

A. General

This section provides information on when a redetermination form is considered to be complete and how to handle an incomplete form.

B. Complete Forms

The redetermination form is considered complete when the beneficiary answered each question and signed the form. Any optional questions not answered to not cause the form to be considered incomplete.

There will be instances in which the beneficiary and/or his/her representative will complete and return a Statement of Facts other than the MC 210 RV or MC 262 (for example the MC 321 HFP, MC 210, or SAWS 2). The worker must accept any of these completed and signed forms for the redetermination and continue to process the redetermination using the information in these forms. The worker shall not require the beneficiary to complete another redetermination form.

If…	Then…
The complete form and/or information provided indicate no change in eligibility,	The redetermination has been completed.
The worker determines there is a change in eligibility,	A timely notice of action (NOA) showing the new budget computation must be provided to the beneficiary.
There are any children in the MFBU changing from zero share of cost (SOC) to SOC,	The worker shall review for Bridging program eligibility.

C. Incomplete, Signed Forms

When a beneficiary returns a signed but incomplete form timely, then the beneficiary is cooperating with the redetermination requirements. Since the form is incomplete and additional information is necessary to determine ongoing Medi-Cal benefits, the worker shall continue with the redetermination process following SB 87 requirements beginning with the *ex parte* review. The worker must narrate each action related to obtaining missing or additional information/verification. The worker shall not terminate Medi-Cal benefits as long as the beneficiary cooperates with the redetermination process.

D. Complete Form without Signature

When a beneficiary returns a complete redetermination form without a signature, it is not necessary to conduct an *ex parte* review or telephone call before mailing the unsigned redetermination form back to the beneficiary with instructions to sign and return the form to the county. The worker should keep a copy of the unsigned form in the case until the signed copy is returned. The worker shall not discontinue Medi-Cal benefits as long as the beneficiary cooperates with the worker.

E. Additional Information Needed

If a beneficiary returns the redetermination form complete with information indicating that there are changes that could affect ongoing eligibility and no verification of these changes is provided, the beneficiary is still considered to be cooperating with the redetermination requirements. Since the required verification was not provided with the redetermination form, the worker must follow the SB 87 requirements. The worker must narrate each action related to obtaining additional information/verification.

F. *Ex Parte*

Before initiating any discontinuance action based on an inability to make an eligibility determination using information supplied by the beneficiary on the redetermination form, the worker must:

1) Conduct an *ex parte* review,

2) Attempt telephone contact with the beneficiary, and

3) Mail the Request for Information form (MC 355) to the beneficiary.

If this process fails to establish continued eligibility for the beneficiary, the worker must send a timely NOA to the beneficiary on the discontinuance of benefits.

G. Forms Not Returned

If a beneficiary fails to return the redetermination form to the county by the requested due date and the redetermination packet is not returned by the post office as undeliverable, the worker shall send a timely 10-day NOA to discontinue Medi-Cal benefits for failure to cooperate with the redetermination requirements. The discontinuance action shall be effective on the last day of the month in which the redetermination is due. The SB 87 process does not apply in this situation because failure of the beneficiary to complete and return the MC 210 RV constitutes a failure to cooperate and not a change in circumstances.

H. Form Returned Within 30 Days of Discontinuance

The table below shows the actions that the worker must take when the redetermination form is returned to the county within 30 days of the discontinuance.

If…	Then the worker must…
The beneficiary returns a signed and completed redetermination form with requested verification to the county within 30 days of the Medi-Cal discontinuance,	Determine eligibility as though the form was submitted in a timely manner.
There is no change reported by the beneficiary and ongoing eligibility exists,	• Rescind the discontinuance with no break in benefits. • Establish a new 12-month period from the first day of the month following the discontinuance action. • Certify the beneficiary for a new 12-month period.
The MFBU moves from zero SOC Medi-Cal to SOC,	• Restore the beneficiary's Medi-Cal benefits and apply the appropriate SOC amount to the correct budget month(s). • Provide the beneficiary with a NOA about the restoration and the applicable SOC amount for the appropriate budget month(s).
Any child in the MFBU is now only eligible for SOC Medi-Cal and the family did not check the box indicating that they did not want their child's information shared with the Healthy Families (HF) program,	• Share the child's information with HF. • Review for the Bridging program.
The beneficiary returns a signed and completed redetermination form within 30 days of the Medi-Cal discontinuance and information provided indicates there are changes to the beneficiary's circumstances, but the information provided is incomplete or not adequate to determine ongoing eligibility,	• Not restore Medi-Cal benefits until the beneficiary provides adequate information/verification to complete the eligibility review. • Contact the beneficiary and inform him/her via telephone or written correspondence that the information/verification provided is not sufficient to rescind their discontinued Medi-Cal benefits and additional information is needed within this 30-day period. • Not send another NOA. • Narrate each action related to obtaining additional information/verification.

The beneficiary provides all necessary information/verifications within this 30-day period and is found to be eligible,	Restore benefits with no break in aid.

I. Form Returned More than 30 Days after Discontinuance

The table below shows the actions that the worker must take when the redetermination form is returned more than 30 days after the discontinuance.

If the beneficiary …	Then the worker must…
Contacts the county or returns the form after Medi-Cal has been discontinued for more than 30 days,	Determine if good cause existed. Each case must be evaluated separately. There will be situations that are unique to the individual beneficiary.

Examples of Good Cause
The beneficiary is unable to read or complete the MC 210 RV form without assistance because the MC 210 RV form is not available in the written language that he/she understands.
The postal service fails to deliver the redetermination packet in a timely manner.
Physical or mental illness or incapacity prevented the beneficiary from submitting the forms in a timely manner.

Has good cause,	Allow the beneficiary to complete the redetermination and restore Medi-Cal without any break in benefits.
Does not have good cause,	Advise the beneficiary that he/she must reapply for Medi-Cal and complete the application and eligibility determination process.

J. Loss of Contact

The table below shows how to handle returned mail or loss of contact during the redetermination process.

If…	Then the worker must…
The redetermination packet is returned with no forwarding address and marked undeliverable,	Follow the SB 87 process.
If the beneficiary's whereabouts remain unknown,	Discontinue the Medi-Cal case and mail a NOA to the last known address.

4.15.4
Completing the Redetermination

A. General

This section provides information on completing the annual redetermination.

B. Redetermination Due Date

The redetermination form is due in the month prior to the month of the redetermination. For example, for a redetermination due in October, the redetermination form must be returned to the worker in September. This allows both the beneficiary and the worker sufficient time to complete the redetermination process.

C. Informing the Beneficiary of the Redetermination

The worker must ensure that the beneficiary understands the redetermination process and requirements, as well as his/her rights and responsibilities under the Medi-Cal program. This notification informs the beneficiary that completing the annual redetermination in a timely manner will ensure continuing benefits if he/she remains eligible and that non-cooperation may cause interruption or discontinuance of Medi-Cal benefits at the end of the twelfth month.

The first step in the redetermination process is to mail the Annual Redetermination Notice and form to the beneficiary. This must be mailed by the last day of the eleventh month. The worker must inform the beneficiary of the date that the redetermination form must be returned in order for benefits to continue. The Medi-Cal Annual Redetermination Notice contains the following information:

- Purpose of the annual redetermination,
- Requirements of the annual redetermination, and
- Date the required forms must be completed and returned to the county for benefits to continue.

D. Required Information

The worker must provide the following information to the beneficiary when completing the redetermination.

Item	Requirements

Rights and Responsibilities	• Narrate that form MC 219, Important Information for Persons Requesting Medi-Cal, was mailed to the beneficiary with the redetermination forms. • It is not necessary for the beneficiary to return a signed copy to the worker. • If a beneficiary has questions or needs an explanation regarding any item on the MC 219, review the Rights and Responsibilities by telephone contact. The worker must narrate the contact.
Child Health and Disability Prevention (CHDP) and Prenatal Care Guidance Program	• Include the CHDP informational brochure in the redetermination packet if there is a person under the age of 21. • If the beneficiary requests more information these programs, or requests a referral for services, enter the appropriate CHDP code. • Note the beneficiary's request or rejection of CHDP services in the County Use Section of the redetermination form.
Medi-Cal General Property Limitations	Include the MC 007, Medi-Cal General Property Limitations, in the redetermination packet. Narrate that the MC 007 was sent.

E. Redetermination Information on MEDS

Workers must check MEDS after the redetermination is complete to be sure that the most recent annual redetermination information was transmitted to MEDS. If the information did not transmit, request an on-line transaction to enter that information.